

CHAPTER 39 LONG-TERM CARE INSURANCE

191—39.1(514G) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514G, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

191—39.2(514G) Authority. This chapter is issued pursuant to the authority vested in the commissioner under Iowa Code section 514G.7 in accordance with the procedures set forth in Iowa Code chapter 17A.

191—39.3(514G) Applicability and scope. Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies and long-term care coverage arrangements delivered or issued for delivery in this state on or after the effective date hereof, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations.

191—39.4(514G) Definitions. For the purpose of these rules, the terms “*Group long-term care insurance*,” “*Commissioner*,” “*Applicant*,” “*Policy*,” “*Preexisting condition*” and “*Certificate*” shall have the meanings set forth in Iowa Code chapter 514G, “Long-Term Care Insurance Act.”

“*Long-term care insurance*” means an insurance policy, insurance contract, insurance certificate, or rider, which is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital. This definition also encompasses group and individual annuities and life insurance policies or riders that provide directly for or supplement long-term care insurance as well as a policy or rider providing for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organizations to the extent they are otherwise authorized to issue life or health insurance.

Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare Supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset-protection coverage, or accident-only coverage, specific disease or specified accident coverage, or limited benefit health coverage. The definition does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor eligibility for those benefits is conditional upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of 191—Chapter 39.

“*Long-term care coverage arrangement*” is a promise that long-term care will be delivered to a person upon need and the meeting of certain contractual requirements. The arrangement is offered to the general public or a sector of the general public at a cost determined by the use of sound actuarial principles based upon the probability of use. This definition does not include self-insurance.

“*Qualified long-term care insurance contract*” or “*federally tax-qualified long-term care insurance contract*” means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as follows:

1. The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

2. The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

3. The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986;

4. The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed;

5. All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

6. The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986.

“*Qualified long-term care insurance contract*” or “*federally tax-qualified long-term care insurance contract*” also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986.

191—39.5(514G) Policy definitions. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

39.5(1) “*Medicare*” shall be defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

39.5(2) “*Mental or nervous disorder*” shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

39.5(3) *Nursing care.*

a. “*Skilled nursing care*” shall not be defined more restrictively than one or more professional services performed for the benefit of the insured on a daily basis, by or under the supervision of a registered nurse, prescribed by a physician, appropriate and consistent with the diagnosis and conditions requiring care.

b. “*Intermediate nursing care*” shall not be defined more restrictively than care which meets all of the above when professional nursing services are delivered on a regular basis but less often than daily.

c. “*Custodial nursing care*” shall not be defined more restrictively than that level of care required to assist an individual in activities of daily living when, due to age complicated by sickness or injury, such care is required. This level of care can be performed by persons without professional skills or training.

39.5(4) “*Nursing facility*” shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

- (1) Be operated pursuant to law; be appropriately licensed or certified;
- (2) Be primarily engaged in providing, in addition to room and board accommodations, skilled or intermediate nursing care under the supervision of a duly licensed physician;

- (3) Provide nursing service by or under the supervision of a registered nurse (R.N.); and

- (4) Maintain a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not include:

- (1) Any home, facility or part thereof used primarily for rest;
- (2) A home or facility for the aged or for the care of drug addicts or alcoholics; or
- (3) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

39.5(5) “*Acute condition*” means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual’s health status.

39.5(6) “*Home health care services*” means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

39.5(7) “*Activities of daily living*” means at least bathing, continence, dressing, eating, toileting and transferring.

39.5(8) “*Adult day care*” means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

39.5(9) “*Bathing*” means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

39.5(10) “*Cognitive impairment*” means a deficiency in a person’s short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

39.5(11) “*Continence*” means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

39.5(12) “*Dressing*” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

39.5(13) “*Eating*” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

39.5(14) “*Exceptional increase*” means only those increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state or due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in rule 191—39.28(514G), exceptional increases are subject to the same requirements as other premium rate schedule increases.

The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

39.5(15) “*Hands-on assistance*” means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

39.5(16) “*Incidental*,” as used in subrule 39.28(10), means that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

39.5(17) “*Personal care*” means the provision of hands-on services to assist an individual with activities of daily living.

39.5(18) “*Qualified actuary*” means a member in good standing of the American Academy of Actuaries.

39.5(19) “*Similar policy forms*” means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Iowa Code section 514G.4(4) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

39.5(20) “*Toileting*” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

39.5(21) “*Transferring*” means moving into or out of a bed, chair or wheelchair.

191—39.6(514G) Policy practices and provisions.

39.6(1) *Renewability.* The terms “*guaranteed renewable*” and “*noncancellable*” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of this chapter. No such policy issued to an individual shall contain renewal provisions other than “*guaranteed renewable*” or “*noncancellable*.”

a. The term “*guaranteed renewable*” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew. Rates may be revised by the insurer on a class basis.

b. The term “*noncancellable*” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

c. Notwithstanding the provisions in 191—subrule 36.5(4), long-term care insurance policies may contain a return of premium or cash value benefit so long as:

(1) The return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

(2) The insurer demonstrates in its filings that the reserve basis for the policies is adequate.

Any advertisement or sales presentation of a long-term care insurance policy with a return of premium or cash value benefit provision shall include a side-by-side comparison of premiums for the same policy with and without the return of premium or cash value benefit provision.

d. The term “*level premium*” may be used only when the insurer does not have the right to change the premium.

e. In addition to the other requirements of this subrule, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986.

39.6(2) Limitations and exclusions.

a. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or disease;

(2) Mental or nervous disorders (however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer’s disease or similar forms of irreversible dementia nor limit coverage for Alzheimer’s disease to the skilled or intermediate level of care);

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

1. War or act of war (whether declared or undeclared);

2. Participation in a felony, riot or insurrection;
3. Service in the armed forces or units auxiliary thereto;
4. Attempted suicide (sane or insane) or intentional self-inflicted injury;
5. Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

Paragraph "a" is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

b. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Iowa Code section 514G.7(3) "b" expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Iowa Code section 514G.7(3) "b."

c. No long-term care insurance policy may be delivered or issued for delivery in this state if the policy conditions eligibility for any benefits other than waiver of premium, postconfinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

39.6(3) Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

39.6(4) Continuation or conversion.

a. Group long-term care insurance issued in this state on or after January 1, 1992, shall provide covered individuals with a basis for continuation or conversion of coverage.

b. For the purposes of this rule, "*a basis for continuation of coverage*" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

c. For the purposes of this rule, "*a basis for conversion of coverage*" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

d. For the purposes of this rule, “*converted policy*” means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured’s age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured’s age at inception of coverage under the group policy replaced.

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) Termination of group coverage resulted from an individual’s failure to make any required payment of premium or contribution when due; or

(2) The terminating coverage is replaced not later than 31 days after termination, by group coverage, effective on the day following termination of coverage, that provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage, and for which the premium is calculated in a manner consistent with the requirements of paragraph “f” of this subrule.

h. Notwithstanding any other provision of this rule, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual’s coverage under the group policy remained in force and effect.

j. Notwithstanding any other provision of this rule, any insured individual whose eligibility for long-term care coverage is based upon the individual’s relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

k. For the purpose of this rule: a “*Managed-Care Plan*” is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

39.6(5) *Discontinuance and replacement.* If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

a. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

39.6(6) *Premiums.*

a. The premiums charged to an insured for long-term care insurance shall not increase due to either:

(1) The increasing age of the insured at ages beyond 65; or

(2) The duration the insured has been covered under the policy.

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under subrule 39.29(6), the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

c. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under subrule 39.29(6), the initial annual premium shall be based on the reduced benefits.

39.6(7) *Electronic enrollment for group policies.* In the case of a group defined in Iowa Code section 514G.4(4), any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

a. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

b. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records; and

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and privileged information is maintained.

The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

191—39.7(514G) Required disclosure provisions.

39.7(1) *Renewability.*

a. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

b. A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

39.7(2) *Riders and endorsements.* Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under an individual long-term care insurance policy, no riders or endorsements may be added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

39.7(3) *Payment of benefits.* A long-term care insurance policy which provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

39.7(4) *Limitations.* If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.”

39.7(5) *Other limitations or conditions on eligibility for benefits.* A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited in Iowa Code section 514G.7(4)“b,” shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits.”

39.7(6) *Disclosure of tax consequences.* With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subrule shall not apply to qualified long-term care insurance contracts.

39.7(7) *Benefit triggers.* Activities of daily living and cognitive impairment shall be used to measure an insured’s need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits.” Any additional benefit triggers shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured’s functional dependency in order for the insured to be eligible for benefits, this too shall be specified.

39.7(8) *Qualified long-term care contracts.* A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

39.7(9) *Nonqualified long-term care contracts.* A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

191—39.8(514G) Prohibition against postclaims underwriting.

39.8(1) All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

39.8(2) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

39.8(3) Except for policies or certificates which are guaranteed issue:

a. The following language shall be set out conspicuously and in close conjunction with the applicant’s signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

39.8(4) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate.

39.8(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners.

191—39.9(514D,514G) Minimum standards for home health care benefits in long-term care insurance policies.

39.9(1) A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

a. By requiring that the insured/claimant would need skilled care in a nursing facility if home health care services were not provided;

b. By requiring that the insured/claimant first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered;

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the provider's licensure or certification;

e. By requiring that the insured/claimant have an acute condition before home health care services are covered;

f. By limiting benefits to services provided by Medicare-certified agencies or providers;

g. By excluding coverage for personal care services provided by a home health aide;

h. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

i. By excluding coverage for adult day care services.

39.9(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.10(514D,514G) Requirement to offer inflation protection.

39.10(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection offers, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

39.10(2) Where the policy is issued to a group, the required offer in subrule 39.10(1) shall be made to the group policyholder; except, if the policy is issued to a group defined in Iowa Code section 514G.4(5) “*d*,” other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

39.10(3) The offer in subrule 39.10(1) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

39.10(4) Insurers shall include the following information in or with the outline of coverage:

a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

39.10(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured’s age, claim status or claim history, or the length of time the person has been insured under the policy.

39.10(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

39.10(7) Inflation protection as provided in this subrule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subrule. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.11(514D,514G) Requirements for application forms and replacement coverage.

39.11(1) Application forms shall include the following questions designed to elicit information whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by Iowa Code section 514G.4(5) “*a*,” the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.

a. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

b. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(1) If so, with which company?

(2) If that policy lapsed, when did it lapse?

c. Are you covered by Medicaid?

d. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

39.11(2) Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

39.11(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name]. Your new policy provides ten days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT

[BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

39.11(4) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name]. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

39.11(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

39.11(6) Life insurance policies that accelerate benefits for long-term care shall comply with this subrule if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 191—Chapter 16. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.12(514G) Reserve standards.

39.12(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Iowa Code section 508.36(3)“a”(7). Claim reserves must also be established when such policy or rider is in claim status.

Reserves for policies and riders subject to this subrule should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to the subrule, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- a. Definition of insured events;
- b. Covered long-term care facilities;
- c. Existence of home convalescence care coverage;
- d. Definition of facilities;
- e. Existence or absence of barriers to eligibility;
- f. Premium waiver provision;
- g. Renewability;
- h. Ability to raise premiums;
- i. Marketing method;
- j. Underwriting procedures;
- k. Claims adjustment procedures;
- l. Waiting period;
- m. Maximum benefit;
- n. Availability of eligible facilities;
- o. Margins in claim costs;
- p. Optional nature of benefit;
- q. Delay in eligibility for benefit;
- r. Inflation protection provisions; and
- s. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

39.12(2) When long-term care benefits are provided other than as in subrule 39.12(1), reserves shall be determined in accordance with sound actuarial standards, applied consistently and accepted by the commissioner of insurance.

191—39.13(514D) Loss ratio.

39.13(1) *Applicability.* This rule shall apply to all long-term care insurance policies or certificates except those covered under rules 191—39.26(514G) and 191—39.28(514G).

39.13(2) *Minimum loss ratio.* Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors including:

- a. Statistical credibility of incurred claims experience and earned premiums.
- b. The period for which rates are computed to provide coverage.
- c. Experienced and projected trends.
- d. Concentration of experience within early policy duration.
- e. Expected claim fluctuation.
- f. Experience refunds, adjustments or dividends.
- g. Renewability features.
- h. All appropriate expense factors.
- i. Interest.
- j. Experimental nature of the coverage.
- k. Policy reserves.
- l. Mix of business by risk classification.
- m. Product features such as long elimination periods, high deductibles and high maximum limits.

39.13(3) *Accelerated benefits.* Subrule 39.13(2) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

- a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Iowa Code section 508.37;
- c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);
- d. The policy illustration meets the applicable requirements of 191—Chapter 14 regarding illustrations; and
- e. An actuarial memorandum is filed with the insurance division that includes:
 - (1) A description of the basis on which the long-term care rates were determined;
 - (2) A description of the basis for the reserves;
 - (3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - (4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

191—39.14(514G) Filing requirement. Prior to an insurer or similar organization's offering group long-term care insurance to a resident of this state pursuant to Iowa Code section 514G.4(5) "d," it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

191—39.15(514D,514G) Standards for marketing.

39.15(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

- a. Establish marketing procedures to ensure that any comparison of policies by its agents or other producers will be fair and accurate.
- b. Establish marketing procedures to ensure that excessive insurance is not sold or issued.
- c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

- d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.
- e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subrule.
- f. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that such a program is available and the name, address and telephone number of the program.
- g. For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to paragraph 39.6(1) "b."
- h. Provide an explanation of contingent benefit upon lapse provided for in 39.29(6) "c."

39.15(2) In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

- a. *Twisting.* Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
- b. *High-pressure tactics.* Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- c. *Cold-lead advertising.* Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

39.15(3) Association marketing.

a. When a group long-term care insurance policy is issued to an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations, the association or associations, or the insurer of the association or associations, shall, prior to advertising, marketing or offering the policy within this state, file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(1) The association or associations hold regular meetings not less than annually to further purposes of the members;

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

b. When a professional, trade, or occupational association is issued a group long-term care policy for its members or retired members or combination thereof, the association shall have as its primary responsibility, when endorsing or selling long-term care insurance, to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(1) The insurer shall file with the insurance division the following material:

1. The policy and certificate;

2. A corresponding outline of coverage; and

3. All advertisements requested by the insurance division.

(2) The association shall disclose in any long-term care insurance solicitation the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and a brief description of the process under which the policies and the insurer issuing the policies were selected.

(3) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(4) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(5) The association shall also:

1. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance who is not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

2. Actively monitor the marketing efforts of the insurer and its agents; and

3. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Numbered paragraphs "1" through "3" shall not apply to qualified long-term care insurance contracts.

(6) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the insurance division the information required in this subrule.

(7) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subrule.

(8) Failure to comply with the filing and certification requirements of this subrule constitutes an unfair trade practice in violation of Iowa Code chapter 507B.

39.15(4) Producer training requirements.

a. Purpose. The purpose of this subrule is to require certain specific minimum training for insurance producers who wish to sell long-term care insurance in Iowa. This additional training is necessary due to the complex nature of long-term care insurance products and to ensure that insurance producers are able to determine whether long-term care insurance products are suitable for consumers and are able to adequately explain to consumers how the long-term care insurance products work. The ultimate goal of this subrule is to ensure that purchasers of long-term care insurance products understand basic features of the products. This subrule applies to all long-term care insurance products sold on or after January 1, 2009.

b. Requirements to sell, solicit or negotiate long-term care insurance.

(1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health or sickness and has completed a one-time training course. The training shall meet the requirements set forth in paragraph “c.”

(2) An individual holding a producer license on January 1, 2009, may not continue to sell, solicit or negotiate long-term care insurance on or after January 1, 2009, unless the individual has completed a one-time training course as set forth in paragraph “c.”

(3) In addition to the one-time training course required in subparagraphs (1) and (2) above, an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in paragraph “c.”

(4) The training requirements of paragraph “c” must be approved as continuing education courses under 191—Chapter 11.

c. Training requirements.

(1) The one-time training course required by this subrule shall be no less than eight credits. The ongoing training required by this subrule shall be no less than six credits every CE term. For purposes of this subrule, “credit” and “CE term” shall be defined as they are defined in rule 191—11.2(505,522B).

(2) The training required under subparagraph (1) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care asset preservation programs, pursuant to 191—Chapter 72, including, but not limited to:

1. State and federal regulations and requirements and the relationship between qualified state long-term care asset preservation programs and other public and private coverage of long-term care services, including Medicaid;

2. Available long-term care services and providers;

3. Changes or improvements in long-term care services or providers;

4. Alternatives to the purchase of private long-term care insurance;

5. The effect of inflation on benefits and the importance of inflation protection; and

6. Consumer suitability standards and guidelines.

(3) The training required by this subrule shall not include training that is specific to an insurer’s or company’s product or that includes any sales or marketing information, materials, or training, other than that required by state or federal law.

d. Requirements for insurers. Insurers subject to this subrule shall obtain verification that a producer has received training required by paragraphs “b” and “c” before a producer is permitted to sell, solicit or negotiate the insurer’s long-term care insurance products, shall maintain records in accordance with the state’s record retention requirements, and shall make the verification and records available to the commissioner upon request.

e. Training obtained in other states. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.16(514D,514G) Suitability.

39.16(1) This rule shall not apply to life insurance policies that accelerate benefits for long-term care.

39.16(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the “issuer”) shall:

- a.* Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
- b.* Train its agents in the use of its suitability standards; and
- c.* Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

39.16(3) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take into consideration the following:

- a.* The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
- b.* The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
- c.* The values, benefits and costs of the applicant’s existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

39.16(4) The issuer, and, when an agent is involved, the agent, shall make reasonable efforts to obtain the information set out in subrule 39.16(3). The efforts shall include presentation of the “Long-Term Care Insurance Personal Worksheet” to the applicant, at the time of or prior to application. The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer’s personal worksheet shall be filed with the commissioner.

A completed personal worksheet shall be returned to the issuer prior to the issuer’s consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

39.16(5) The issuer shall use the suitability standards it has developed pursuant to this rule in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

39.16(6) Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

39.16(7) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance” shall be provided. The form shall be in the format contained in Appendix C, in not less than 12-point type.

39.16(8) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

39.16(9) The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of applicants who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

191—39.17(514G) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

191—39.18(514G) Standard format outline of coverage. This rule, which is not applicable to life policies with long-term care riders attached, implements, interprets and makes specific the provisions of Iowa Code section 514G.7(1) in prescribing a standard format and the content of an outline of coverage.

39.18(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

39.18(2) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

39.18(3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

39.18(4) The commissioner shall prescribe the standard format, including style, arrangement, and overall appearance and content of an outline of coverage.

39.18(5) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

39.18(6) The outline of coverage shall contain no material of an advertising nature.

39.18(7) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

39.18(8) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

39.18(9) Format for outline of coverage:

[COMPANY NAME]
[ADDRESS — CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or substantially similar language, must appear as follows in the outline of coverage.]